REQUEST FOR NEW OR RENEWAL OF OPTIONAL SERVICES FOR ASSISTED LIVING CENTERS

Facility_____
Location_____

(FOR DOH USE)
APPROVAL
BY_____
DATE_____

[ ] **MEDICATION ADMINISTRATION** [ARSD 44:04:04:12.01.(2)]
Complete the attached form for medication administration and include any requested information. Enclose a copy of current license for the registered nurse in charge of medication administration. Enclose proof of staff training, including instructor, length of instruction and names of participants.

[ ] YES [ ] NO

[ ] **ACCEPTANCE OF COGNITIVELY IMPAIRED RESIDENTS** [ARSD 44:04:04:12.01(3)]
Enclose a two-week staffing schedule indicating licensed staff or those trained to administer medications. Enclose proof of training to staff on care of the cognitively impaired, including instructor, length of instruction, and names of participants. Our facility has a working exit alarm system that is activated 24-hours per day, seven days a week, on all unattended doors. ☐ Yes ☐ No. **The Department cannot approve this optional service unless Medication Administration is also offered.**

[ ] YES [ ] NO

[ ] **ACCEPTANCE OF PHYSICALLY IMPAIRED RESIDENTS** [ARSD 44:04:04:12.01(4)]
Our facility has a working call system. ☐ Yes ☐ No.

[ ] YES [ ] NO

[ ] **ACCEPTANCE OF RESIDENTS INCAPABLE OF SELF-PRESERVATION** [ARSD 44:04:04:12.01(5)]
Our facility has a complete automatic sprinkler system installed or meets health care occupancy Standards of 2000 Life Safety Code. ☐ Yes ☐ No. Submit two-week staffing schedule.

[ ] YES [ ] NO

[ ] **ACCEPTANCE OF RESIDENTS DEPENDENT ON SUPPLEMENTAL OXYGEN** [ARSD 44:04:04:12.01(6)]
Our oxygen storage area meets NFPA 99 Standards. Enclose proof of staff training on use of supplemental oxygen, including instructor, length of instruction and participants

[ ] YES [ ] NO

[ ] **ACCEPTANCE OF RESIDENTS REQUIRING THERAPEUTIC DIETS** [ARSD 44:04:04:12.01(7)]
Enclose a copy of dietitian's license.

[ ] YES [ ] NO

ARSD 44:04 requires assisted living centers provide staff to meet the care needs of the residents served and have documentation that assures that the individual needs of residents are identified and addressed.

I verify that the information contained in this request is true and correct.

Administrator's Signature_____ Date_____

Instructions:

- Please check all optional services you are requesting approval to offer.
- Submit this form along with any requested information to DOH.
- This information will not be returned. Please make a copy for your records
- Make sure your form is signed.

SOUTH DAKOTA DEPARTMENT OF HEALTH
Office of Health Care Facilities Licensure and Certification
ASSISTED LIVING CENTERS MEDICATION ADMINISTRATION

Facility_____
Location_____

Administrative Rules of South Dakota 44:04:04:12.01(2) permits medication administration in an assisted living center by facility staff when the facility meets certain requirements:

A registered nurse (RN) must be responsible for the program of medication administration. The facility must document authorization to administer or delegate administrations of medications.

1. Verification of current South Dakota license as either a RN or LPN.
   a. Name of nurse:_____
   b. License # with expiration date:_____
   c. RN Supervisor for LPN_____
   d. License # with expiration date RN Supervisor_____

2. Documentation either of employment or a contractual arrangement.
   a. Employment _____yes_____no Date employed:_____
      Schedule of hours anticipated: Please attach.

   b. Contract _____yes_____no
      Dates of contract_____
      Duties specified including schedule of supervisory visits:

If the nurse delegates medication administration to an unlicensed assistive person (UAP), that person must be trained by a registered nurse or registered pharmacist. The trainer must have two (2) years of clinical experience. (ARSD 20:48:04:01)

3. a. Verification of current licensure of the RN or RPh instructor.
      1). Name and discipline of instructor:_____
      2). License # with expiration date:_____

   b. Documentation of approval of the training course: Attach copy of training approval letter from Board of Nursing.

Each unlicensed assistive person who administers medications must have participated in no less than 16 hours of classroom instruction and an additional 4 hours of clinical or laboratory instruction and successfully completed an examination.

3. Training and testing:
   a. Dates and location of instructions:_____
   b. Name of instructor:_____
   c. Names of UAPs approved:_____